LRB-2828

2003 DRAFTING REQUEST

Bill

Received: **06/11/2003**

Received By: **mlief**

Wanted: **As time permits**

Identical to LRB:

For: **Mark Miller (608) 266-5342**

By/Representing:

This file may be shown to any legislator: **NO**

Drafter: **mlief**

May Contact:

Addl. Drafters:

Subject: **Education - handicapped ed.**

Extra Copies: **PG**

Submit via email: **YES**

Requester's email: **Rep.Miller@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Physical restraints in schools

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?				_____			Local
/1	mlief 07/10/2003	kfollett 07/10/2003 kfollett 07/17/2003	jfrantze 07/17/2003	_____ _____ _____ _____	sbasford 07/17/2003		Local

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/3	mlief 10/23/2003	kfollett 10/28/2003	chaugen 10/28/2003	_____ _____	lnorthro 10/28/2003	lnorthro 01/20/2004	

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for Assm. per Dave Zehren

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May Contact:

Addl. Drafters:

Subject: **Education - handicapped ed.**

Extra Copies: **PG**

Submit via email: **YES**

Requester's email: **Rep.Miller@legis.state.wi.us**

Carbon copy (CC:) to: Jeff Spitzer-Resnick (spitznick@w-c-a.org)

Pre Topic:

No specific pre topic given

Topic:

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	mlief	7/17	7/17	7/17 PG			

FE Sent For:

<END>

Grant, Peter

From: Miller, Steve
Sent: Thursday, June 05, 2003 3:58 PM
To: Grant, Peter
Subject: FW: Physical Restraint in Schools drafting

Peter,
Please advise.
Steve

-----Original Message-----
From: Miller, Mark
Sent: Thursday, June 05, 2003 2:52 PM
To: Miller, Steve
Cc: Kuhn, Jamie; 'spitznick@w-c-a.org'; 'nkvander@students.wisc.edu'
Subject: Physical Restraint in Schools drafting request

Mr. Miller

Attached are drafting instructions for legislation requested by the Wisconsin Coalition for Advocacy to clarify the appropriate use of physical restraints in schools. I'm not sure which LRB attorney is the most suitable for this task since it covers a number of subject areas. Please assign the request to whomever you deem most appropriate Let me know who was assigned. The contact person at Wisconsin Coalition for advocacy is Jeff Spitzer-Resnick, 267-0214, spitznick@w-c-a.org. The drafter should feel free to contact him if you have questions regarding the specifics of this request.
Thank you.
Mark Miller

Mark Miller
48th Assembly District
P.O. Box 8953
Madison, WI 53708
Phone 608.266.5342, FAX 608.282.3648
rep.miller@legis.state.wi.us

Limiting the Use of Seclusion and Restraints in Wisconsin Schools

Definitions

Serious Behavioral Problems are behaviors which are self-injurious or assaultive or cause property damage and other severe behavior problems that are pervasive and for which instructional/behavioral approaches specified in the student's individualized education program (IEP) are found to be ineffective.[i]

Behavioral Intervention is the design, implementation, and evaluation of individual or group instructional and environmental modifications, including programs of behavioral instruction, to produce significant improvements in human behavior through skill building and the reduction of problematic behavior. [ii]

Behavioral Intervention Plan is a written document which is developed by a child's IEP team when the student exhibits a serious behavior problem that significantly interferes with the implementation of the student's IEP.

Child – A child is a person who has not attained the age of 18 years except for special education students who are covered up to age 21, except for the purposes of prosecuting a person who is alleged to have violated a state or federal criminal law. [iii]

Emergency situation – is when it is necessary to control unpredictable, spontaneous behavior which poses a clear and present danger of serious physical harm to the student or others which cannot be immediately prevented by a response less restrictive than the temporary application of a technique (by a trained staff member) used to contain the behavior.[iv]

Exclusion means the removal of a student to a supervised area for a limited period of time during which the student has an opportunity to regain self-control and is not receiving instruction including special education.[v]

Free Appropriate Public Education "means special education and related services that are provided at public expense and under public supervision and direction, meet the standards of the department, include an appropriate preschool, elementary or secondary school education and are provided in conformity with an individualized education program."[vi]

Individual Education Plan (IEP) – "Individualized education program means a written statement for a child with a disability that is developed, reviewed and revised in accordance with Wis. Stat. Ann. 115.787."[vii]

Mechanical Restraint- The term mechanical restraint means the use of any device as a means of restricting a student's freedom of movement or normal access to any portion of the student's body and that the student cannot easily remove. [viii]

Non Public School means a school that receives funds from the Department of Public Instruction for the purpose of providing special education and related services to students with disabilities.[ix]

Physical Restraint- The term physical restraint means a personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Physical restraint does not include

a. briefly holding a student in order to calm or comfort the student;

b. holding a student's hand or arm to escort the student safely from one area to another;

c. intervening or breaking up a fight.[x]

Positive Behavior Interventions are procedures a teacher can use in order to positively intervene whenever a student displays, or is likely to display, a targeted serious behavior problem. [xi]

Positive Behavior Intervention Plan must include the following:

1. A summary of information from the functional behavioral assessment;

2. An objective and measurable and measurable description of the targeted serious behaviors and positive replacement behaviors;

3. Goals and objectives specific to the targeted behaviors;

4. A detailed description of the behavioral interventions to be used and the circumstances for their use;

5. Schedules for recording the frequency of interventions and demonstrations of replacement behaviors;

6. Criteria for determining when the interventions will be phased out or replaced with less intense or less frequent interventions;

7. The extent to which interventions will be used in the student's home and in other settings;

8. Specific dates for the administrators or in the case of a child with a disability the IEP team to review the behavior intervention program's effectiveness.[xii]

Public schools-"Public schools are the elementary and high schools supported by public taxation."[xiii]

Restraint – means the use of physical force or a mechanical device to restrict the free movement of all or a portion of a student's body.[xiv]

School Personnel means an individual employed by a public agency or nonpublic school.[xv]

Seclusion – The term seclusion means a behavioral control technique involving a locked box, locked closet, or locked room that:

a. is designated solely to seclude a person[xvi]

b. seclusion is not the same as a time-out [xvii]

Child With A Disability means a child with mental retardation, hearing impairments, (including deafness) speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments or specific learning disabilities; and who by reason thereof needs special education and related services. The use of restraint and seclusion should only be used against a student in an emergency situation. This also includes special needs children who often suffer the greatest trauma due to the use of seclusion and restraint.[xviii]

Time-Out – The term time-out means a behavioral management technique that is part of an approved treatment program and may involve the separation of the student from the class in a non-locked setting for the purpose of calming. Time-Out is not seclusion.[xix]

B. **General Requirements for the Use of Restraints and Seclusion**

1. In general, physical restraints and seclusion may only be imposed on a student in emergency circumstances and only to ensure the immediate physical safety of the student, other students, the teacher, or other staff members after the least restrictive interventions have been determined to be ineffective.[xx]

A. **Requirements for the Use of Physical Restraint**

1. Physical restraint may be used only in the following circumstances:

a. Non-physical interventions would be effective; and

b. the student's behavior poses a threat of imminent, serious, physical harm to self and others.[xxi]

B. Requirements for the Use of Seclusion

1. The use of seclusion is prohibited in public agencies and non public schools unless:

a. There is an emergency situation and seclusion is necessary to protect a student or another person after other less intrusive interventions have failed or been deemed inappropriate.[xxii]

b. The student's IEP or behavioral intervention plan describe the specific behaviors and circumstances in which seclusion may be used; or

c. The parents have otherwise provided written consent for the use of seclusion.

C. Requirements for the Use of Mechanical Restraint.

a. The use of mechanical restraint is prohibited in public agencies and non public schools unless a public agency or non public school is certified to meet the requirements of the Joint Commission for the Accreditation of Health Care Organizations.

b. Nothing in this chapter prevents school personnel from using a protective or stabilizing device as

I. prescribed by a health care professional;

II for a student with a disability in accordance with the student's IEP; OR

III as prescribed in the student's behavioral intervention plan.[xxiii]

D. Descriptions of the ~~G~~General Requirements of the Seclusion Room

a. The room ~~must~~ be free of objects, clutter and fixtures with which a ~~student~~ could self-inflict bodily harm.

b. The seclusion room should give school personnel an adequate view of the ~~student~~ at all times.

c. The seclusion room ~~must~~ be equipped with adequate lighting and ventilation at all times.[xxiv]

E. Role of the Teacher Monitoring the Seclusion Room

a. The teacher shall view a student placed in seclusion at all times; and

b. provide the student placed in the seclusion room with:

I. an explanation of the behavior that resulted in their ~~r~~removal;

II. a list (either orally given or written) which instructs the student on the requirements that he or she must satisfy ~~in order~~ to be returned to the learning environment.

III. a teacher must reassess a child every 15 minutes with thirty minutes being the maximum time a child can be placed in the seclusion room at one time unless an emergency exists.[xxv]

F. Prohibited uses of Seclusion and Restraint

This statute prohibits any of the following types of seclusion and restraint.

1. Any seclusion or restraint designed or likely to cause physical pain.

2. The release of noxious, toxic, or otherwise unpleasant sprays, mists, or substances near the student's eyes or face.

3. Any seclusion or restraint that denies adequate water, physical comfort, or access to the bathroom.

4. Any use of seclusion and restraint that subjects the student to ridicule, humiliation, or excessive emotional trauma.

5. Any use of material or objects which immobilize both hands and feet, except the prone containment or similar techniques which may be used by trained staff as a limited emergency measure to prevent the child from harming themselves, their classmates, another teacher, or other staff members.

6. The use of restraint by untrained staff is prohibited.

7. Any intervention that precludes adequate supervision of the student

8. Any intervention that deprives the student of one or more of his senses.

9. Force exceeding what is reasonable and necessary under the circumstances.[xxvi]

G. Training of Staff in the techniques of Seclusion and Restraint

1. Required training in Restraint and Seclusion is required for staff.

A. Training shall consist of:

a. An introduction to the school's restraint policy.

b. The teaching of positive interventions that may preclude the need for restraint.

c. An informational session on the types of restraints and related safety considerations including information regarding the increased risk of injury to a student when restraint is used.[xxvii]

B. **Staff authorized to use Restraint.**

a. No school staff are authorized to use restraints on students unless they first receive a training by recognized crisis intervention experts on administering physical restraint in accordance with known medical or psychological limitations and or behavioral intervention plans applicable to the individual student.[xxviii]

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[i] Modified definition of 5 CCR 3001 Inglewood California Regulation

[ii] Modified definition of 5 CCR 3001 Inglewood California Regulation

[iii] Wis. Stat. Ann 948.01(1)

[iv] Inglewood California Regulation 5 CCR 3052

[v] The above section is a Modification of Title 13 A Chapter 04 11 of Maryland's Proposed Regulation on Restraint and Seclusion.

[vi] Wis. Stat. Ann 115.76(7)

[vii] Wis. Stat. Ann. 115.76(9)

[viii] The above section is a modification of Title 13 A Chapter 04 (4) of the Proposed Maryland State Regulation on Restraint and Seclusion

[ix] The above section is a Modification of Title 13 A Chapter 04 (11) of the Proposed Maryland State Regulation on Restraint and Seclusion.

[x] The above section is a Modification of Title 13 A Chapter 04 11 B of the Proposed Maryland State Regulation on Restraint and Seclusion.

[xi] California Inglewood Regulation 5. C.C.R. Sec 3001 (f)

[xii] California Inglewood Regulation 5 C.C.R. Sec 3001 (f).

[xiii] Wis. Stat. Ann. 115.01(1)

[xiv] Modification of Texas Statute 37.0021 (b)(1)

[xv] The above section is a Modification of Title 13 A Chapter 04 16 of the Maryland State Regulation on Restraint and Seclusion

[xvi] Modification of Texas statute 37.0021 (b)(2)

[xvii] Definition borrowed from. Section 595 HCFA Restraint and Seclusion Regulations for Children's Psychiatric Treatment Facilities With Amendments.

[xviii] 20 USC §1401 (3)(a)(I) AND (ii); 34 CFR § 300.7

[xix] Modification of Section 595 HCFA Restraint and Seclusion Regulations for Children's Psychiatric Treatment Facilities with Amendments.

[xx] Modified Requirements section of Section 595 HCFA Restraint and Seclusion Regulations for Children's Psychiatric Treatment Facilities With Amendments.)

[xxi] Massachusetts 603 CMR 46:00 Statute on Physical Restraint §46.04 (1)(a)(b)

[xxii] The above section is a Modification of Title 13 A Chapter 04 (B) (i. ii. iii.) of the Proposed Maryland State Regulation on Restraint and Seclusion.

[xxiii] The above section is a Modification of Title 13 A Chapter 04 .05 (a) (b) (i) (ii) of the Proposed Maryland State Regulation on Restraint and Seclusion.

[xxiv] The above section is a Modification of Title 13 A Chapter 04 .05 (B) (2) (i. ii. iii.) of the Proposed Maryland Regulation on Restraint and Seclusion.

[xxv] The above section is a Modification of Title 13 A Chapter 04 .05) (B) (3) (a) (b) (i) (ii) of the Proposed Maryland State Regulation on Restraint and Seclusion.

[xxvi] The above section is modeled after Title 5 California Code of Regulations §5146.3 (H)

[xxvii] Massachusetts 603 CMR 46.00 Physical Restraint Statute § 46.03 (2)

HCFA = Health Care Financey Administrati
— in 1999, HCFA implem
Medicare rule designed to protect
patients from improper use of
restraint + seclusion

TITLE 5. Education
Division 1. State Department of Education
Chapter 3. Handicapped Children
Subchapter 1. Special Education
Article 1. General Provisions
§3001. Definitions.

§3001. Definitions.

 • Note • History

In addition to those found in Education Code sections 56020-56033, Public Law 94-142 as amended (20 USC 1401 et seq.), and Title 34, Code of Federal Regulations, Part 300 and 301, the following definitions are provided:

(a) "Applicant" means an individual, firm, partnership, association, or corporation who has made application for certification as a nonpublic, nonsectarian school, or agency.

(b) "Assessment and development of the individualized education program" (IEP) means services described in Education Code sections 56320 et seq. and 56340 et seq.

(c) "Behavioral emergency" is the demonstration of a serious behavior problem: (1) which has not previously been observed and for which a behavioral intervention plan has not been developed; or (2) for which a previously designed behavioral intervention is not effective. Approved behavioral emergency procedures must be outlined in the special education local planning area (SELPA) local plan.

(d) "Behavioral intervention" means the systematic implementation of procedures that result in lasting positive changes in the individual's behavior. "Behavioral intervention" means the design, implementation, and evaluation of individual or group instructional and environmental modifications, including programs of behavioral instruction, to produce significant improvements in human behavior through skill acquisition and the reduction of problematic behavior. "Behavioral interventions" are designed to provide the individual with greater access to a variety of community settings, social contacts and public events; and ensure the individual's right to placement in the least restrictive educational environment as outlined in the individual's IEP. "Behavioral interventions" do not include procedures which cause pain or trauma. "Behavioral interventions" respect the individual's human dignity and personal privacy. Such interventions shall assure the individual's physical freedom, social interaction, and individual choice.

(e) "Behavioral intervention case manager" means a designated certificated school/district/county/nonpublic school or agency staff member(s) or other qualified personnel pursuant to subsection (ac) contracted by the school district or county office or nonpublic school or agency who has been trained in behavior analysis with an emphasis on positive behavioral interventions. The "behavioral intervention case manager" is not intended to be a new staffing requirement and does not create any new credentialing or degree requirements. The duties of the "behavioral intervention case manager" may be performed by any existing staff member trained in behavior analysis with an emphasis on positive behavioral interventions, including, but not limited to, a teacher, resource specialist, school psychologist, or program specialist.

(f) "Behavioral intervention plan" is a written document which is developed when the individual exhibits a serious behavior problem that significantly interferes with the implementation of the goals and objectives of the individual's IEP. The "behavioral intervention plan" shall become

part of the IEP. The plan shall describe the frequency of the consultation to be provided by the behavioral intervention case manager to the staff members and parents who are responsible for implementing the plan. A copy of the plan shall be provided to the person or agency responsible for implementation in noneducational settings. The plan shall include the following:

(1) a summary of relevant and determinative information gathered from a functional analysis assessment;

(2) an objective and measurable description of the targeted maladaptive behavior(s) and replacement positive behavior(s);

(3) the individual's goals and objectives specific to the behavioral intervention plan;

(4) a detailed description of the behavioral interventions to be used and the circumstances for their use;

(5) specific schedules for recording the frequency of the use of the interventions and the frequency of the targeted and replacement behaviors; including specific criteria for discontinuing the use of the intervention for lack of effectiveness or replacing it with an identified and specified alternative;

(6) criteria by which the procedure will be faded or phased-out, or less intense/frequent restrictive behavioral intervention schedules or techniques will be used;

(7) those behavioral interventions which will be used in the home, residential facility, work site or other noneducational settings; and

(8) specific dates for periodic review by the IEP team of the efficacy of the program.

(g) "Board" means the State Board of Education.

(h) "Certification" means authorization by the State Superintendent of Public Instruction (Superintendent) for a nonpublic school or nonpublic agency to service individuals with exceptional needs under a contract pursuant to the provisions of Education Code section 56366 (c).

(i) "Contracting education agency," means school district, special education local plan area, or county office of education.

(j) "Credential" means any valid credential, life diploma, permit, or document in special education or pupil personnel services issued by, or under the jurisdiction of, the State board of Education prior to 1970 or the California Commission on Teacher Credentialing, which entitles the holder thereof to perform services for which certification qualifications are required.

(k) "Department" means the California Department of

(l) "Department of Consumer Affairs" means the California Department of Consumer Affairs.

(m) "Dual enrollment" means the concurrent attendance of the individual in a public education agency and a nonpublic school and/or a nonpublic agency.

(n) "Feasible" as used in Education Code section 56363(a) means the individualized education program team:

(1) has determined the regular class teacher, special class teacher, and/or resource specialist possesses the necessary competencies and credentials/certificates to provide the designated instruction and service specified in the individualized education program, and

(2) has considered the time and activities required to prepare for and provide the designated instruction and service by the regular class teacher, special class teacher, and/or resource specialist.

(o) "Free appropriate public education" means special education and related services that:

(1) have been provided at public expense, under public supervision and direction and without charge:

education or related services, or, in the absence of such requirements, the state-education-agency-approved or recognized requirements, and adheres to the standards of professional practice established in federal and state law or regulation, including the standards contained in the California Business and Professions Code. Nothing in this definition shall be construed as restricting the activities in services of a graduate needing direct hours leading to licensure, or of a student teacher or intern leading to a graduate degree at an accredited or approved college or university, as authorized by state laws or regulations.

(z) "Related services" means transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, social work services, counseling services, including rehabilitation counseling, and medical services, except that such medical services shall be for diagnostic and evaluation purposes only) as required to assist an individual with exceptional needs to benefit from special education, and includes the early identification and assessment of disabling conditions in children. Related services include, but are not limited to, Designated Instruction and Services. The list of related services is not exhaustive and may include other developmental, corrective, or supportive services if they are required to assist a child with a disability to benefit from special education. Each related service defined under this part may include appropriate administrative and supervisory activities that are necessary for program planning, management, and evaluation.

(aa) "Serious behavior problems" means the individual's behaviors which are self-injurious, assaultive, or cause serious property damage and other severe behavior problems that are pervasive and maladaptive for which instructional/behavioral approaches specified in the student's IEP are found to be ineffective.

(ab) "Specified education placement" means that unique combination of facilities, personnel, location or equipment necessary to provide instructional services to an individual with exceptional needs, as specified in the IEP, in any one or a combination of public, private, home and hospital, or residential setting. The IEP team shall document its rationale for placement in other than the pupil's school and classroom in which the pupil would otherwise attend if the pupil were not disabled. The documentation shall indicate why the pupil's disability prevents his or her needs from being met in a less restrictive environment even with the use of supplementary aids and services.

(ac) "Special education" means specially designed instruction, at no cost to the parents, to meet the unique needs of individuals with exceptional needs whose educational needs cannot be met with modification of the regular instruction program, and related services, at no cost to the parent, that may be needed to assist these individuals to benefit from specially designed instruction.

(ad) "Specialized physical health care services" means those health services prescribed by the individual's licensed physician and surgeon requiring medically related training for the individual who performs the services and which are necessary during the school day to enable the individual to attend school.

(ae) "Superintendent" means the State Superintendent of Public Instruction.

(af) "Temporary physical disability" means a disability incurred while an individual was in a regular education class and which at the termination of the temporary physical disability, the individual can, without special intervention, reasonably be expected to return to his or her regular education class.

NOTE

Authority cited: Sections 56100 and 56523(a), Education Code. Reference: Sections 33000, 33300, 49423.5, 56026, 56034, 56320, 56361, 56366, 56520 and 56523, Education Code; Section 2, Article IX, Constitution of the State of California; Sections 1401(8) and (17), United States Code, Title 20; and

the IEP team from initially developing the behavioral intervention plan in sufficient detail to include schedules for altering specified procedures, or the frequency or duration of the procedures, without the necessity for reconvening the IEP team. Where the intervention is to be used in multiple settings, such as the classroom, home and job sites, those personnel responsible for implementation in the other sites must also be notified and consulted prior to the change.

(i) Emergency Interventions. Emergency interventions may only be used to control unpredictable, spontaneous behavior which poses clear and present danger of serious physical harm to the individual or others and which cannot be immediately prevented by a response less restrictive than the temporary application of a technique used to contain the behavior.

(1) Emergency interventions shall not be used as a substitute for the systematic behavioral intervention plan that is designed to change, replace, modify, or eliminate a targeted behavior.

(2) Whenever a behavioral emergency occurs, only behavioral emergency interventions approved by the special education local planning area (SELPA) may be used.

(3) No emergency intervention shall be employed for longer than is necessary to contain the behavior. Any situation which requires prolonged use of an emergency intervention shall require staff to seek assistance of the school site administrator or law enforcement agency, as applicable to the situation.

(4) Emergency interventions may not include:

(A) Locked seclusion, unless it is in a facility otherwise licensed or permitted by state law to use a locked room;

(B) Employment of a device or material or objects which simultaneously immobilize all four extremities, except that techniques such as prone containment may be used as an emergency intervention by staff trained in such procedures; and

(C) An amount of force that exceeds that which is reasonable and necessary under the circumstances.

(5) To prevent emergency interventions from being used in lieu of planned, systematic behavioral interventions, the parent and residential care provider, if appropriate, shall be notified within one school day whenever an emergency intervention is used or serious property damage occurs. A "Behavioral Emergency Report" shall immediately be completed and maintained in the individual's file. The report shall include all of the following:

(A) The name and age of the individual;

(B) The setting and location of the incident;

(C) The name of the staff or other persons involved;

(D) A description of the incident and the emergency intervention used, and whether the individual is currently engaged in any systematic behavioral intervention plan; and

(E) Details of any injuries sustained by the individual or others, including staff, as a result of the incident.

(6) All "Behavioral Emergency Reports" shall immediately be forwarded to, and reviewed by, a designated responsible administrator.

(7) Anytime a "Behavioral Emergency Report" is written regarding an individual who does not have a behavioral intervention plan, the designated responsible administrator shall, within two days, schedule an IEP team meeting to review the emergency report, to determine the necessity for a functional analysis assessment, and to determine the necessity for an interim behavioral intervention plan. The IEP team shall document the reasons for not conducting an assessment and/or not developing an interim plan.

(8) Anytime a "Behavioral Emergency Report" is written regarding an individual who has a behavioral intervention plan, any incident involving a previously unseen serious behavior

problem or where a previously designed intervention is not effective should be referred to the IEP team to review and determine if the incident constitutes a need to modify the plan.

(9) "Behavioral Emergency Report" data shall be collected by SELPAs which shall report annually the number of Behavioral Emergency Reports to the California Department of Education and the Advisory Committee on Special Education.

(j) SELPA Plan. The local plan of each SELPA shall include procedures governing the systematic use of behavioral interventions and emergency interventions. These procedures shall be part of the SELPA local plan.

(1) Upon adoption, these procedures shall be available to all staff members and parents whenever a behavioral intervention plan is proposed.

(2) At a minimum, the plan shall include:

(A) The qualifications and training of personnel to be designated as behavioral intervention case managers, which shall include training in behavior analysis with an emphasis on positive behavioral interventions, who will coordinate and assist in conducting the functional analysis assessments and the development of the behavioral intervention plans;

(B) The qualifications and training required of personnel who will participate in the implementation of the behavioral intervention plans; which shall include training in positive behavioral interventions;

(C) Special training that will be required for the use of emergency behavioral interventions and the types of interventions requiring such training; and

(D) Approved behavioral emergency procedures.

(k) Nonpublic School Policy. Nonpublic schools and agencies, serving individuals pursuant to Education Code Section 56365 et seq., shall develop policies consistent with those specified in subsection (i) of this section.

(*l*) Prohibitions. No public education agency, or nonpublic school or agency serving individuals pursuant to Education Code Section 56365 et seq., may authorize, order, consent to, or pay for any of the following interventions, or any other interventions similar to or like the following:

(1) Any intervention that is designed to, or likely to, cause physical pain;

(2) Releasing noxious, toxic or otherwise unpleasant sprays, mists, or substances in proximity to the individual's face;

(3) Any intervention which denies adequate sleep, food, water, shelter, bedding, physical comfort, or access to bathroom facilities;

(4) Any intervention which is designed to subject, used to subject, or likely to subject the individual to verbal abuse, ridicule or humiliation, or which can be expected to cause excessive emotional trauma;

(5) Restrictive interventions which employ a device or material or objects that simultaneously immobilize all four extremeties, including the procedure known as prone containment, except that prone containment or similar techniques may be used by trained personnel as a limited emergency intervention pursuant to subsection (i);

(6) Locked seclusion, except pursuant to subsection (i)(4)
(A);

(7) Any intervention that precludes adequate supervision of the individual; and

(8) Any intervention which deprives the individual of one or more of his or her senses.

(m) Due Process Hearings. The provisions of this chapter related to functional analysis assessments and the development and implementation of behavioral intervention plans are subject to the due process hearing procedures specified in Education Code Section 56501 et seq. No hearing officer may order the implementation of a behavioral intervention that is otherwise

(b) A teacher may remove from class a student:

(1) who has been documented by the teacher to repeatedly interfere with the teacher's ability to communicate effectively with the students in the class or with the ability of the student's classmates to learn; or

(2) whose behavior the teacher determines is so unruly, disruptive, or abusive that it seriously interferes with the teacher's ability to communicate effectively with the students in the class or with the ability of the student's classmates to learn.

(c) If a teacher removes a student from class under Subsection (b), the principal may place the student into another appropriate classroom, into in-school suspension, or into an alternative education program as provided by Section 37.008. The principal may not return the student to that teacher's class without the teacher's consent unless the committee established under Section 37.003 determines that such placement is the best or only alternative available. The terms of the removal may prohibit the student from attending or participating in school-sponsored or school-related activity.

(d) A teacher shall remove from class and send to the principal for placement in an alternative education program or for expulsion, as appropriate, a student who engages in conduct described under Section 37.006 or 37.007. The student may not be returned to that teacher's class without the teacher's consent unless the committee established under Section 37.003 determines that such placement is the best or only alternative available.

Added by Acts 1995, 74th Leg., ch. 260, § 1, eff. May 30, 1995.

§ 37.0021. Use of Confinement, Restraint, Seclusion, and Time-Out

(a) It is the policy of this state to treat all students with dignity and respect. A student with a disability may not be confined in a locked box, locked closet, or other specially designed locked space as either a discipline management practice or a behavior management technique.

(b) In this section:

(1) "Restraint" means the use of physical force or a mechanical device to restrict the free movement of all or a portion of a student's body.

(2) "**Seclusion**" means a behavior management technique in which a

student is confined in a locked box, locked closet, or locked room that:

(A) is designed solely to seclude a person; and

(B) contains less than 50 square feet of space.

(3) "Time-out" means a behavior management technique in which, to provide a student with an opportunity to regain self-control, the student is separated from other students for a limited period in a setting:

(A) that is not locked; and

(B) from which the student is not physically prevented from leaving.

(c) A school district employee or volunteer or an independent contractor of a district may not place a student in **seclusion**. This subsection does not apply to the use of **seclusion** in a facility to which the following law, rules, or regulations apply:

(1) the Children's Health Act of 2000, Pub. L. No. 106-310, any subsequent amendments to that Act, any regulations adopted under that Act, or any subsequent amendments to those regulations;

(2) 40 T.A.C. Sections 720.1001-720.1013; or

(3) 25 T.A.C. Section 412.308(e).

(d) The commissioner by rule shall adopt procedures for the use of restraint and time-out by a school district employee or volunteer or an independent contractor of a district in the case of a student receiving special education services under Subchapter A, Chapter 29. A procedure adopted under this subsection must:

(1) be consistent with:

(A) professionally accepted practices and standards of student discipline and techniques for behavior management; and

(B) relevant health and safety standards; and

(2) identify any discipline management practice or behavior management technique that requires a district employee or volunteer or an independent contractor of a district to be trained before using that practice or technique.

(e) In the case of a conflict between a rule adopted under Subsection (d) and a rule adopted under Subchapter A, Chapter 29, the rule

GENERAL LAWS OF MASSACHUSETTS

PART I.
ADMINISTRATION OF THE GOVERNMENT.

TITLE XII.
EDUCATION.

CHAPTER 71. PUBLIC SCHOOLS.

Chapter 71: Section 37G. Corporal punishment of pupils prohibited; use of physical restraint; regulations.

Section 37G. (a) The power of the school committee or of any teacher or any other employee or agent of the school committee to maintain discipline upon school property shall not include the right to inflict corporal punishment upon any pupil.

(b) The provisions of this section shall not preclude any member of the school committee or any teacher or any employee or agent of the school committee from using such reasonable force as is necessary to protect pupils, other persons, and themselves from an assault by a pupil. When such an assault has occurred, the principal shall file a detailed report of such with the school committee.

(c) The board of education shall promulgate regulations regarding the use of physical restraint for students. Such regulations shall not preclude any teacher or employee or agent of the school from using reasonable force to protect pupils, other persons and themselves from an assault by a pupil as set forth above in section (b). Such regulations shall require training of all personnel authorized to administer any forms of restraint. Such regulations shall provide for procedures for notification to the department and to the parents.

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Part II

Department of Health and Human Services

Health Care Financing Administration

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42 CFR Part 482

Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Interim Final Rule

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 482

[HCFA-3018-IFC]
RIN 0938-AJ56

Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights

the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690-7890).

FOR FURTHER INFORMATION CONTACT: Monique Howard, OTR (410-786-3869); Julie Moyers (410-786-6772); Anita Panicker, RN, LCSW (410-786-5646); or Rachael Weinstein, RN (410-786-6775).

I. Background

A. General

On December 19, 1997, we published a proposed rule entitled ``Medicare and Medicaid Programs; Hospital Conditions of Participation; Provider Agreements and Supplier Approval'' at 62 FR 66726 to revise the entire set of conditions of participation (CoPs) for hospitals that are found at 42 CFR part 482. The CoPs are the requirements that hospitals must meet to participate in the Medicare and Medicaid programs. These CoPs are intended to protect patient health and safety and to ensure that high quality care is provided to all patients. The State survey agencies (SAs), under contract with us, survey hospitals to assess compliance with the CoPs. The SAs conduct these surveys using the State Operations Manual (SOM) (HCFA Publication No. 7). The SOM contains the regulatory language of the CoPs as well as interpretive guidelines and survey probes that elaborate on regulatory intent and give in-depth detail about how to maintain compliance. The SOM also outlines the survey process and provides guidance for State administration of the survey program. Under Sec. 489.10(d), the SAs determine whether hospitals meet the CoPs and make corresponding recommendations to us about the hospital's certification, (that is, whether the hospital has met the standards required to provide Medicare and Medicaid services and receive Federal and State reimbursement).

Under section 1865 of the Act and Sec. 488.5 (Effect of JCAHO or AOA accreditation of hospitals), hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA) are not routinely surveyed for compliance by the SAs but are deemed to meet the requirements in the CoPs based on their accreditation.

B. Why a Patients' Rights CoP Is Needed

In recent years, State surveyors, patient advocacy groups, the media, and the general public have brought complaints about hospitals violating patients' rights to our attention. These violations have consisted of denying or frustrating a patient's access to care, denying a patient's full involvement in his or her treatment, disregarding a patient's advance directives, denying a patient's access to his or her medical records, or inappropriately using seclusion or restraints. Particularly within the past year, the public, media, and the Congress have grown increasingly concerned about the need to ensure basic protections for patient health and safety in hospitals, especially with regard to the use of restraints and seclusion. The Hartford Courant, a Connecticut newspaper, heightened public awareness of this issue with a series of articles in October 1998 citing the results of a study that identified 142 deaths from seclusion or restraints use in behavioral health treatment facilities over the past 10 years. The majority were adolescent deaths.

C. Intent To Examine Restraint and Seclusion in Other Settings

(5) freedom from the use of seclusion or restraint of any form unless clinically necessary. In the preamble, we solicited comments on a more prescriptive approach to the use of restraints and seclusion and provided relevant examples.

Although we proposed codifying the new Patients' Rights CoP as Sec. 482.10, in the final rule it is designated as Sec. 482.13 to coordinate with the numbering system used in the current regulations. When the remaining hospital CoPs are finalized, we will renumber the standards in part 482.

Our commitment to the revision of the remaining hospital CoPs to focus on patient-centered, outcome-oriented care remains unchanged. We continue to work on analysis of the over 60,000 comments received on the proposed rule and will finalize the remaining hospital CoPs in the future.

IV. Comments and Responses

Of the 60,000 comments received on the December 1997 proposed rule, approximately 300 focused on the Patients' Rights CoP. Comments were received from hospitals, mental health treatment facilities, professional associations, accrediting bodies, SAs, patient advocacy groups, and members of the general public. Half of the comments, and the strongest opposition, came in response to the proposed fifth standard under Patients' Rights--seclusion and restraints. While many of the respondents did not favor prescriptive regulations that extended beyond the proposed regulations text, some welcomed more prescriptive language under the standard for seclusion and restraints.

A summary of the comments received on the five standards, major issues, and our responses follows.

A. Notice of Rights

We proposed that a hospital must inform each patient of his or her rights in advance of furnishing care and that the hospital must have a grievance process and indicate who the patient can contact to express a grievance.

Comment: Commenters indicated that what constitutes sufficient notification needs to be clarified. One commenter stated this requirement should be satisfied by providing written displays of patients' rights in the hospital lobby and in each patient's room, and in verbal or written form with initial and additional information included in the admission packet.

Response: We appreciate the suggestions of how and where patients' rights should be displayed or conveyed. However, hospitals will need flexibility to establish policies and procedures that effectively ensure that patients and their representatives have the information necessary to exercise their rights. These policies and procedures will need to address how, where, and when to notify patients of the full gamut of rights to which they are entitled under the Act. As hospitals assess the effectiveness of their proactive notification techniques, they need flexibility to continuously improve their performance in promoting patients' rights.

This CoP covers hospitals of varying sizes operating in a wide range of locations, serving diverse populations, with a variety of required notices; thus, flexibility and creativity to allow for the effective implementation of this requirement without undue burden is critical. Therefore, we are not including further prescriptive language detailing exactly where, how, when, and by whom this requirement must be carried out.

While we are committed to preserving flexibility on this point, we

but the most extreme cases.

(3) ``The patient will receive his or her medical records within the time frame prescribed by State or local law.'' We would defer to either State or local guidance on this point.

The criteria we have set out above, that would describe circumstances that might limit access by patients to their hospital medical records, are not being incorporated into this final rule. Rather, we are raising them now as examples of the narrow areas in which providers should exercise discretion. Once we have reviewed the comments, we will consider whether further guidance is necessary.

Comment: One commenter stated the regulation should require records to be supplied at a fair market rate.

Response: Pricing must not create a barrier to the individual receiving his or her medical records. Records should be supplied at a cost not to exceed the community standard. If State law establishes a rate for the provision of records, State law should be followed. However, in the absence of State law, the rate charged by organizations such as the local library, post office, or a local commercial copy center that would be selected by a prudent buyer can be used as a comparative standard.

We are finalizing the requirement as proposed and believe that charging excessive fees for copies of a patient's medical record would constitute a violation of the Patients' Rights CoP as this practice could be used to frustrate the legitimate efforts of individuals to gain access to their own medical records. We expect that we would receive and investigate complaints if hospitals charged excessive fees for medical records.

Comment: Some commenters stated that consideration should be given to risk management issues involved in the release of incomplete medical records.

Response: We are unsure whether the commenter is referring to a closed record that may be incomplete or to a request for a copy of a current, open record that, until the patient is discharged, will be incomplete. In either situation, we believe it is a patient's inherent right to have access to his or her clinical record. A hospital may decide to provide a staff member to review the record with the patient as necessary to minimize misunderstandings and respond to concerns.

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H. Seclusion and Restraint

(1) We Received Approximately 150 Comments Regarding the Proposal That Patients Have the Right To Be Free From the Use of Seclusion or Restraint, of Any Form, as a Means of Coercion, Convenience, or Retaliation by Staff

Comment: None of the commenters voiced an objection to the addition of this standard under Patients' Rights.

Response: Since we proposed the rule in 1997, interest in the use of seclusion and restraint and its consequences has increased markedly. Part of this heightened awareness is due to media attention devoted to this topic. One of the most controversial series of newspaper reports appeared in October 1998 in Connecticut's Hartford Courant. The articles cited the results of a study that identified 142 deaths from seclusion and restraint use in behavioral health treatment facilities, including psychiatric hospitals and psychiatric treatment units in general hospitals, over the past 10 years. Restraint use has also been covered in the broadcast media and has been investigated by the General Accounting Office. All of this attention has generated a great deal of concern for patient safety and well-being within the public, private,

and regulatory sectors.

While we find the reports of deaths associated with restraint use disturbing, we are equally concerned with the impact that restraint use has on acute and long-term care patients. The prevalence of injuries and accidents involving restraint is difficult to gauge. If manufacturers learn of a death or serious injury caused by a medical device, they must report it to the Food and Drug Administration (FDA). Device user facilities (hospitals, nursing homes, outpatient treatment facilities, outpatient diagnostic facilities) must report a death of one of their patients caused by the medical device to FDA and the manufacturer, and a serious injury to the manufacturer only. No other entities are required to report to FDA or the manufacturer.

Research indicates that the potential for injury or harm with the use of restraint is a reality. In a 1989 article published in the Journal of the American Geriatrics Society, Evans and Strumpf pointed to an association between the use of physical restraint and death during hospitalization (Evans, LK and Strumpf, NE: Tying down the elderly: A review of the literature on physical restraint. J Am Geriatr Soc (1989) 37:65-74; also see Robbins, LJ, Boyko E, Lane, J, et al.: Binding the elderly: A prospective study of the use of mechanical restraint in an acute care hospital. J Am Geriatr Soc (1987) 35:290; Frengley, JD and Mion, LC: Incidence of physical restraints on acute general medical wards. J Am Geriatr Soc (1986) 34:565; Strumpf, NE and Evans, LK: Physical restraint of the hospitalized elderly: Perceptions of patients and nurses. Nursing Research (1998) 37:132.) The FDA estimates that at least 100 deaths from the improper use of restraints may occur annually. Mion et al. further noted that, ``Some evidence exists that the use of physical restraints is not a benign practice and is associated with adverse effects, such as longer length of hospitalization, higher mortality rates, higher rates of complications, and negative patient reactions. Physical restraints have a detrimental effect on the psychosocial well-being of the patient'' (see Mion et al.: A further exploration of the use of physical restraints in hospitalized patients. Jour Am Geriatr Soc (1989) 37:955; Schafer, A: Restraints and the elderly: When safety and autonomy conflict. Can Med Assoc J (1985) 132:1257-1260).

Research findings on the impact of restraints use have lead to research on and development of alternative methods for handling the behaviors and symptoms that historically prompted the application of restraint. However, various studies provide evidence that restraint is still being used when alternate solutions are available (see Donat, DC: Impact of a mandatory behavior consultation on seclusion/restraint utilization in psychiatric hospitals. J Behav Ther Exp Psychiatry (1998 March) 29:1, 13-9; Dunbar, J: Making restraint-free care work. Provider (1997 May) 75-76, 79; and Moss, RJ: Ethics of mechanical restraints. Hasting Center Report (1991 Jan-Feb) 21(1):22-25.)

While we acknowledge that in some emergency situations the use of restraint may be the least potentially harmful way to protect the individual's safety or that of others, the patient's right to be free from restraint is paramount. Restraint use should be the exception to the rule, not a standard practice. The question that arises is how we and the medical community, with the common goal of the well-being of each patient, can eliminate the inappropriate use of restraint and can ensure the safety and health of the patient in emergency situations where a restraint is applied. In considering how to achieve these goals, we refer to the article by Evans and Strumpf:

`` * * * the consideration of the anticipated length of time in restraint, goals of care, and the likely outcome for the patient become extremely important questions to answer in those instances

where restraints are contemplated or in use * * * Further, more attention to staff education regarding selection of appropriate restraints by type and size and their proper application and monitoring seems to be warranted if restraint-related accidental injuries and deaths are to be avoided.'' (J Am Geriatr Soc (1989) 37:70).

In its Safety Alert of July 15, 1992, the FDA echoed the need for training to decrease the incidence of deaths and injuries involving restraining devices. The FDA suggested that institutions provide in-service training for staff as regularly as possible, including a demonstration of proper application of restraint. Given the stated need for training if accidental injuries and deaths are to be avoided and the use of alternative measures promoted, we have added language to the final rule that will require a training program on restraint for staff. We have also noted that these training programs should review alternatives to restraint and seclusion, to teach skills so that staff who have direct patient contact are well equipped to handle behaviors and symptoms as much as possible without the use of restraints or seclusion.

In the final rule, we have added the word ``discipline'' to the standard statement to read, ``The patient has the right to be free from the use of seclusion or restraint, of any form, as a means of coercion, discipline, convenience, or retaliation by staff.'' Discipline is not an acceptable reason for secluding or restraining a patient. In the treatment environment, it is impossible to distinguish between ``discipline'' and ``punishment.''

Another addition to the final rule are definitions of ``physical restraint,'' ``drug that is used as a restraint,'' and ``seclusion.'' We believe that codifying the definitions of these terms will provide a clear legal basis for the enforcement of these standards.

We have decided upon a division of the restraint and seclusion standard in the final rule. As we began work on the final rule, we discovered a pattern of differences between an intervention used in the provision of acute medical and surgical care and one used to manage behavioral symptoms. This difference was situation-specific rather than necessarily linked to provider type. While the definition of ``restraint'' spans care settings, the circumstances and expected outcomes for restraints use vary.

In the final rule, we have attempted to differentiate between situations where a restraint is being used to provide acute-level medical and surgical care and those where restraint or seclusion is used to manage behavior.

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This approach is similar to that adopted in existing standards that JCAHO has created for restraint and seclusion. When a restraint is applied in the course of acute medical and surgical care, the intervention is generally not undertaken because of an unanticipated outburst of severely aggressive or destructive behavior that poses an imminent danger to the patient and others. In medical and surgical care, a restraint may be necessary to ensure that an intravenous (IV) or feeding tube will not be removed, or that a patient who is temporarily or permanently mentally incapacitated will not reinjure him or herself by moving after surgery has been completed. Using a device such as an IV arm board to provide medication that, if skipped, would cause the patient considerable injury or harm may be the least restrictive intervention that accomplishes the necessary administration of the medication. The use of a restraint in this circumstance is

necessary for the patient's well-being (to receive effective treatment) when less restrictive interventions, such as keeping the patient's arm free and mobile have been determined to be ineffective.

Depending on the patient's diagnosis and health status, whether the acute medical and surgical care patient requires constant monitoring while restrained or can be monitored and reassessed at regular intervals is a matter of clinical judgment. Additionally, seclusion is not an intervention selected to help with the provision of medical or surgical services; therefore, references to seclusion have been removed from the final standard that appears as subsection (e).

A critical point to remember is that these standards are not specific to the treatment setting, but to the situation the restraint is being used to address. For example, if a hospital has a wing for psychiatric patients where it uses restraint or seclusion to manage behavior, it must meet the restraint and seclusion behavior management standard for those patients.

The use of restraints or seclusion to manage behavior is an emergency measure that should be reserved for those occasions when an unanticipated, severely aggressive or destructive behavior places the patient or others in imminent danger. While different factors may precipitate this type of psychiatric, behavioral, and physical outburst for an individual patient, the need for rapid assessment and continuous monitoring is applicable in each case.

Accordingly, we are accepting commenters' suggestions to regulate the time frames within which certain actions must occur in the behavior management scenario. We are adopting the concept of time-limited orders that appears in JCAHO's 1999 Hospital Accreditation Standards. Specifically, the intent statement for standard TX.7.1.3.1.8 provides that written orders for restraint or seclusion for behavioral health patients are limited to 4 hours for adults, 2 hours for children and adolescents ages 9 to 17, or 1 hour for patients under age 9. These time frames were created for JCAHO's use by a committee of experts in the field. We stress, however, that these time frames represent the maximum time intervals for which each order can be written. Physicians or licensed independent practitioners may write orders for shorter increments of time. A licensed independent practitioner is any individual permitted by law and by the hospital to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. Additionally, under regulation, while the patient is being restrained or secluded, his or her status must be continually monitored, assessed, and reevaluated, with an eye toward releasing him or her from the restraint or seclusion at the earliest possible time. We believe that these factors will ensure that the patient is restrained or secluded for as brief a time as possible. In addition, we are requiring that if the restraint or seclusion order is written by a physician or licensed independent practitioner other than the ``treating'' physician, the treating physician must be consulted as soon as possible The ``treating'' physician is the physician who is responsible for the management and care of the patient. We believe that this is important because the ``treating'' physician may have information regarding the patient's history which may have a significant impact on the selection of restraint or seclusion as an intervention. For example, the patient may have a history of sexual abuse and restraints or seclusion may actually cause psychological harm.

JCAHO also states in its explanation of intent for standard TX.7.1.3.1.7 that each licensed independent practitioner best carries out his or her responsibility when he or she participates in daily reviews of restraints and seclusion use related to his or her patients.

We are adopting a parallel philosophy by specifying in the regulation that an order for restraint or seclusion may only be renewed in the previously mentioned increments (4 hours for adults; 2 hours for patients ages 9 to 17; 1 hour for patients under 9) for up to a total of 24 hours--to that point, the practitioner must reevaluate his or her patient face-to-face before writing a new order. We believe that it is appropriate to recognize JCAHO's work in this area and maintain consistency between Federal and accreditation standards when possible.

In situations where a restraint must be used for behavior management, increased vigilance is required because of the heightened potential for harm or injury as the patient struggles or resists. Furthermore, there is an immediate need for assessment of what has triggered this behavior and for continuous monitoring of the patient's condition. To address the need for quick assessment of the condition, we are specifying that the physician or licensed independent practitioner see the patient face-to-face within 1 hour of the application of the restraint or the use of seclusion.

The standard for restraint use in the provision of acute medical and surgical services and the standard for restraints and seclusion use for behavior management are built on the same foundation; however, the behavior management standard contains more rigorous requirements for the timeliness of actions that must be taken by a physician or other licensed independent practitioner who is granted authority under State law and by the hospital to order restraints use or seclusion. The creation of two restraints standards does not represent any lessening in our commitment to restraint reduction and, as much as possible, elimination in both the provision of acute care and behavior management situations. The distinction does acknowledge, however, that it may not be reasonable to have identical standards for two very different situations. The absence of time frames for the acute care standard should not be construed as permission to restrain patients without timely interaction with the physician or other licensed independent practitioner who is permitted by the State and the hospital to order restraint. When restraint is used to provide acute medical or surgical care, we still expect the patient to be continually assessed, monitored, and reevaluated by hospital staff. The patient's care needs will dictate how frequently reassessment by a physician or other licensed independent practitioner is necessary. In any case, we expect the discontinuation of the restraint at the earliest possible time.

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(2) We Proposed That if Seclusion and Restraints Are Used (Including Drugs Used as Restraints), They Must be Used in Accordance With the Patient's Plan of Care, Used Only as a Last Resort, in the Least Restrictive Manner Possible, and Removed or Ended at the Earliest Possible Time

Comment: One commenter suggested that there needs to be better understanding of why seclusion and restraints are used, and development of efforts to reduce their use. However, this commenter did not believe further prescriptive Federal regulation is necessary.

Response: There is a need to understand why seclusions and restraints are used; however, the reasons behind the use of restraints have been studied and to some extent documented (see Strumpf NE and Evans, LK: Physical restraint of the hospitalized elderly: Perceptions of patients and nurses. Nursing Research (1988) 37:132-137; Evans LK and Strumpf NE: Tying down the elderly: A review of the literature on physical restraint. Jour Amer Geriatr Soc (1989) 37:65-74; Janelli, LM: Physical restraint use in acute care settings. J Nurs Care Qual (1995 Apr) 9(3) 86-92.) Various studies substantiate that restraints are

to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with Sec. 489.100 of this part (Definition), Sec. 489.102 of this part (Requirements for providers), and Sec. 489.104 of this part (Effective dates).

(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

(c) Standard: Privacy and safety. (1) The patient has the right to personal privacy.

(2) The patient has the right to receive care in a safe setting.

(3) The patient has the right to be free from all forms of abuse or harassment.

(d) Standard: Confidentiality of patient records. (1) The patient has the right to the confidentiality of his or her clinical records.

(2) The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not

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frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its recordkeeping system permits.

(e) Standard: Restraint for acute medical and surgical care. (1) The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff. The term ``restraint'' includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

(2) A restraint can only be used if needed to improve the patient's well-being and less restrictive interventions have been determined to be ineffective.

(3) The use of a restraint must be--

(i) Selected only when other less restrictive measures have been found to be ineffective to protect the patient or others from harm;

(ii) In accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order a restraint. This order must--

(A) Never be written as a standing or on an as needed basis (that is, PRN); and

(B) Be followed by consultation with the patient's treating physician, as soon as possible, if the restraint is not ordered by the patient's treating physician;

(iii) In accordance with a written modification to the patient's plan of care;

(iv) Implemented in the least restrictive manner possible;

(v) In accordance with safe and appropriate restraining techniques; and

(vi) Ended at the earliest possible time.

(4) The condition of the restrained patient must be continually assessed, monitored, and reevaluated.

(5) All staff who have direct patient contact must have ongoing education and training in the proper and safe use of restraints.

(f) Standard: Seclusion and restraint for behavior management. (1)

The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. The term ``restraint'' includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. Seclusion is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.

(2) Seclusion or a restraint can only be used in emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective.

(3) The use of a restraint or seclusion must be--

(i) Selected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm;

(ii) In accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order seclusion or restraint. The following requirements will be superseded by existing State laws that are more restrictive:

(A) Orders for the use of seclusion or a restraint must never be written as a standing order or on an as needed basis (that is, PRN).

(B) The treating physician must be consulted as soon as possible, if the restraint or seclusion is not ordered by the patient's treating physician.

(C) A physician or other licensed independent practitioner must see and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention.

(D) Each written order for a physical restraint or seclusion is limited to 4 hours for adults; 2 hours for children and adolescents ages 9 to 17; or 1 hour for patients under 9. The original order may only be renewed in accordance with these limits for up to a total of 24 hours. After the original order expires, a physician or licensed independent practitioner (if allowed under State law) must see and assess the patient before issuing a new order.

(iii) In accordance with a written modification to the patient's plan of care;

(iv) Implemented in the least restrictive manner possible;

(v) In accordance with safe appropriate restraining techniques; and

(vi) Ended at the earliest possible time.

(4) A restraint and seclusion may not be used simultaneously unless the patient is--

(i) Continually monitored face-to-face by an assigned staff member; or

(ii) Continually monitored by staff using both video and audio equipment. This monitoring must be in close proximity the patient.

(5) The condition of the patient who is in a restraint or in seclusion must continually be assessed, monitored, and reevaluated.

(6) All staff who have direct patient contact must have ongoing education and training in the proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion.

(7) The hospital must report to HCFA any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion.